

Governor Janice K. Brewer

State of Arizona Naturopathic Physicians Medical Board

1400 W. Washington, Ste. 300 Phoenix, AZ 85007

Executive Director; Ms. Gail Anthony Phone: 602-542-8242 Fax: 602-542-3093 Website: www.aznd.gov

APPLICATION FOR CERTIFICATE TO ENGAGE IN A CLINICAL TRAINING PROGRAM

Note: Completed application must be sent to Board's office via the Naturopathic College. Include the following with your application:

- APPLICATION/ CERTIFICATE FEE: MONEY ORDER in the amount of \$100.00 made payable to "AZ ND BOARD"
- MONEY ORDER in the amount of \$22.00 made payable to "DPS"
- Completed Fingerprint Card

Height:

Weight:

- Copy of Southwest College Student ID

I,	, hereby make applicat	ion to the State of Arizona
Naturopathic Physicians Medical Board (Board) for a medicine as a naturopathic medical student to diagno	ose and treat patients in the pra	ctice of naturopathic medicine under
the supervision of a physician licensed by the Board		
section 32-1501, et. Seq. and any applicable provision	on of Arizona Administrative Co	de, Title 4, Chapter 18, Section R4-
18-101, et seq.	and have the Daniel to abtain	Colored Control (because the least on the colored
<u>I understand</u> : The filing of this application grants a that I am attending and from any licensing agency or		
in my application to the Board is adequate cause fo		
my application based on a felony conviction or a		
Board, upon notice to me, may hold a hearing to reve		
the Board. That if I cease to be enrolled at the medic		
patients under the supervision of a physician license	d by this Board or by a physicia	n licensed pursuant to Chapter 13
(M.D.), 17 (D.O) or 29 (M.D.(H)) of this title that the E		
cancel or revoke the certificate that is issued to me b		
Engage in a Clinical Training Program issued to		
and day of original issue whether or not a notice		
know when his/her certificate expires and to rene	ew that certificate on time. I h	ave read and understand A.R.S 32-
1560		
Printed Name of Applicant:		
<u> </u>		
Home Address: Number & Street		Apt. #
Number & Street		Арт. #
City:, State:	, Zip: Telephone:	()
• ———		,
Cell phone number: ()	Email Address:	
Place of Birth:		
City	State	Country
Date of Birth:/ Social Security		[] Female [] Male
	(SS required)	

Hair Color:

Eye Color:

Name of School:							
A 11							
Address:Number of	& Street		City	State	Zip		
Name of Clinical Training	g Program:						
Address:							
Address:Number of	& Street		City	State	Zip		
Date of Clinical Entry: _	//	Date of Completing Clinic	cal Training:	//			
Name of Supervising Ph	ysician for Clinical T	raining:					
Name of Chief Medical	Officer Clinical Train	ing Program:					
	Answ	er the Following Ques	tions				
<u> </u>		ged with, convicted of, or en	tered into a plea of	no contest to a felony			
or a misdemeanor? YesNo Have you ever had a license/certificate, including a driver's license, suspended or revoked by any agency? YesNo Have you ever been disciplined by any agency for any act of unprofessional conduct as defined in Arizona Revised Statutes, Section 32-1501? YesNo In lieu of disciplinary action by an agency, have you ever entered a consent agreement or stipulation							
with a licensing agency? YesNo Do you have a complaint pending before any agency?YesNo Have you ever been found guilty of being medically incompetent?YesNo Have you ever been a defendant in any malpractice matter that resulted in a settlement or judgment?YesNo Do you have any medical condition that in any way impairs or limits your ability to practice medicine?							
*An applicant is required to s that a conviction and/or crimin that you can answer "No" to the	nal offense has been pardon						
*The Criminal Justice Information Report received by the Board from the United States Department of Justice Federal Bureau of Investigation is inclusive of all arrests including juvenile arrests even when records are expunged by a court of law. In a written supplemental statement to the Board, an applicant is required to list all arrests, pleas and convictions, jail or prison time served and any probation served. Failure to provide complete information for questions answered Yes on this page may require the applicant to appear before the Board for a personal interview.							
Subscribed And Sworn To	Before A Notary Public:						
	<u> </u>						
County of							
Print the Applicant's Full Name: first duly sworn upon his or her oath deposes and says all of the following: I am the person named in this application. I have read and understand the contents of this application. The information contained in this application is true and correct to the best of my ability and the information submitted is without fraud, deceit or misrepresentation. I hereby authorize any hospital, institution, organization, personal physician, past or present employer, past or present business or professional associate or any local, state, federal or foreign governmental agency to release any information to the State of Arizona in connection with my application and state that a photocopy of this authorization shall have the same effect as the original. I also authorize the State of Arizona Naturopathic Physicians Board of Medical Examiners, or its successor, to release any information submitted by me, upon request, to the public or to any licensing agency, or to any other person, when such request is required or permitted by Arizona Revised Statutes. I acknowledge that any falsification in my application is cause to deny my application or for the Naturopathic Physicians Board of Medical Examiners to hold a hearing to revoke any naturopathic medical student internship, preceptorship or preceptorship training registration that is issued to me by the Board. I authorize the Board to tape record any application interview that is conducted of myself in regards to this application. Signature of Applicant:							
Subscribed and sworn to be							
Notary Public Signature			_	(OFFICI	AL STAMP)		
Notary Public Commission							
Office Use	Receipted	Emailed		Agenda			